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No. 88-1503

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,
Petitioners,
v.
ROBERT HARMON, Director of the Mississippi Department of Health, and DONALD LAMKINS, Administrator of the Missouri Rehabilitation at Mount Vernon,
Respondents,
v.
THAD C. MCCANSE,
Guardian Ad Litem,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Missouri

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BRIEF AMICUS CURIAE OF THE SOCIETY FOR THE RIGHT TO DIE, INC. IN SUPPORT OF PETITIONERS

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BRIEF AMICUS CURIAE OF THE SOCIETY FOR THE RIGHT TO DIE, INC. IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS

The Society for the Right to Die, Inc. ("The Society") is a national not-for-profit educational organization founded in 1938. Its focus is advocacy of the individual's right

to control medical treatment, including the right to choose to reject life-sustaining treatment and avoid the futile prolongation of the dying process.[1]

Ever since the New Jersey case, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), articulated a constitutional basis to grant the request of the father of Karen Ann Quinlan to discontinue the use of the respirator maintaining her in a persistent vegetative state, the legal, ethical and practical questions surrounding this very modern dilemma have been demanding concrete answers.

The Society is probably the most consulted single source of information in this country on all aspects of the right to control one's medical treatment. It is involved in an extensive educational effort with the legal, medical, ethical, and religious communities, as well as the general public, with regard to patients' rights, living wills and medical decisionmaking procedures. Multiple disciplines are involved in the question of when medical treatment can be stopped; patients, doctors, nurses, social workers, religious leaders, lawyers, teachers, and the media need guidance about what is or is not permissible.

The Society supports the enactment of living will legislation and statutory authorization for surrogate decisionmaking procedures. Forty-one states and the District of Columbia now have either natural death legislation or statutes authorizing decisionmaking by an appointed surrogate. The Society provides technical drafting advice to legislators based on its practical experience with legislation nationwide. The Society also distributes the appropriate documents for living wills and medical durable power of attorney forms in every state, free of charge. In 1988 alone, as a result of requests from the public, the Society distributed nearly half a million living wills and related documents throughout the country. As a

[1] This brief has been filed on consent of the parties.

result of a single "Dear Abby" newspaper column in the fall of 1988, the Society received almost 100,000 pieces of mail requesting living wills.

Since 1984, the Society has filed amicus briefs in virtually every right to die appellate case in the country, and has been granted oral argument in some forums. The Society also offers a legal subscription service, which tracks legislative and judicial developments nationwide, and is read widely in the legal, medical and bioethical community.

An extremely significant service of the Society is its nationwide counseling of families confronted by treatment decisions. The Society's doctor, social worker and attorneys provide mediation services and advice on decisionmaking to hospitals, doctors, patients and their loved ones on a daily basis. These calls have sometimes resulted in landmark judicial decisions, but more often reflect the everyday reality of society's capacity to control the dying process, and the conflicts which can arise between health care institutions, doctors, patients and their families. The constant stream of requests for assistance to the Society mirrors the current problem of making life-and-death medical decisions in an uncertain legal climate. While a medical and ethical national consensus has emerged which permits family decisionmaking on behalf of incompetent patients, the legal framework is in dissaray, in large part due to the Missouri Supreme Court's decision in *Cruzan v. Harmon*, Appendix to the Petition For a Writ of Certiorari. ("Pet. App.") Where the prior uniformity of appellate decisions made it possible for the Society to give generally applicable guidance, it has now become increasingly difficult to do so.

Joe Cruzan contacted the Society for such guidance in 1986, when he and his family had accepted the hopelessness of Nancy Cruzan's condition. Mr. Cruzan wanted to know about his daughter's rights. He was advised that Missouri law at that time did not address the rights

of those who had not executed living wills and were maintained by tube feeding in a permanently unconscious state. The Cruzans chose to become the first legal case to press the issue of whether Missouri citizens have any constitutional or common law rights to determine their medical destiny. The Missouri Supreme Court's decision now adversely affects every United States citizen's right to have medical decisions made in conformity with his or her own values.

INTRODUCTION AND SUMMARY OF ARGUMENT

Approximately two million Americans die every year. Eighty percent of those deaths take place in a hospital or nursing home, and nearly all of those deaths involve a decision by someone to do or *not* to do something which could, for some time, avert the moment of that death and prolong the dying process. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICAL AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT: A REPORT OF THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS, 16-18 (1983).

Nancy Cruzan was not allowed to die by the Missouri Supreme Court, although the American Medical Association, the American Academy of Neurology, the Missouri State Medical Association, and eight other appellate state courts which have ruled on the issue would authorize her parents' request to terminate tube feeding.[2] While

[2] Since the 1976 *Quinlan* case, twenty-two jurisdictions have issued "right-to-die" rulings authorizing the termination of life support for patients in a variety of circumstances.

Arizona: *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987).

California: *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988).

[Continued]

the number of patients in a persistent vegetative state is relatively small, the decision of the Missouri Supreme Court has thrown into question every individual's right to choose a medically appropriate course of treatment if it conflicts with the values of four appellate judges.

[1] [Continued]

Colorado: *In re Rodas*, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22, 1987, *as modified*, April 3, 1987).

Connecticut: *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989).

Delaware: *In re Severns*, 425 A.2d 156 (Del. Ch. 1980).

District of Columbia: *Tune v. Walter Reed Army Medical Hospital*, 602 F. Supp. 1452 (D. D.C. 1985).

Florida: *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984).

Georgia: *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984).

Hawaii: *Wilcox v. Hawaii*, Civ. No. 860116 (Hawaii Cir. Ct. 5th Cir. June 16, 1986).

Iowa: *Morgan v. Olds*, 417 N.W.2d 232 (Iowa Ct. App. 1987).

Louisiana: *In re PVW*, 424 So. 2d 1015 (La. 1982).

Maine: *In re Gardner*, 534 A.2d 947 (Me. 1987).

Massachusetts: *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

Michigan: *In re Culham*, No. 87-340537-AZ (Mich. Cir. Ct. Oakland County Dec. 15, 1987).

Minnesota: *In re Torres*, 357 N.W.2d 332 (Minn. 1984).

New Jersey: *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

New York: *In re Storer*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

North Dakota: *In re Bayer*, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 11, and Dec. 11, 1987.

Ohio: *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (Ct. Com. Pl. 1980).

Pennsylvania: *In re Jane Doe*, 16 Phila. 229 (Pa. Ct. Com. Pl. 1987).

Rhode Island: *Gray v. Romeo*, 697 F. Supp. 580 (D. R.I. 1988).

Washington: *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988).

Nancy Cruzan has become a symbol. Despite the Missouri Supreme Court's acknowledgment of her family's loving motives, they are stripped of any input into their daughter's care and are condemned to a thirty year bedside vigil in order to protect unnamed and unspecified others. Nancy's current condition is a result of a new kind of medical capacity and she deserves to be treated in the way nationally recognized experts recommend—consistent with her wishes, as articulated by her family, to forgo artificial nutrition and hydration. While other courts have grappled with the question of standards for deciding medical care for incompetent patients, no other court has handed over total power to decide to the State.

ARGUMENT

The decision below took from the Cruzan family any right to determine that the kind of medical care which will be rendered to their daughter is the treatment *she* would want. It granted the power of medical decision-making to the *government* rather than allowing an individualized decision to be made, which would take into account the patient, Nancy Gruzan. A Rhode Island federal court phrased the same issue as follows:

> Essentially this controversy concerns the question of whether or not the State can insist that a person in a vegetative state incapable of intelligent sensation, whose condition is irreversible, may be required to submit to medical care under circumstances in which the patient prefers not to do so.

Gray v. Romeo, 697 F. Supp. 580, 584 (D. R.I. 1988). In sharp contrast to Missouri's answer to the question, the Rhode Island federal court ruled that there was *no* state interest which could outweigh the patient's constitutional right to a personalized decision. The State of Missouri, unlike every other state to have considered the issue, adopted a very specific point of view regarding the "sanctity of life," cloaked it as the governmental interest in the "preservation of life," and denied Nancy Cruzan her fundamental right to privacy, as articulated in *Griswold v. Connecticut*, 381 U.S. 479 (1965) and its progeny.

The Missouri Supreme Court's refusal to authorize the termination of treatment conflicts with the decisions of every other highest state court in its reasoning.[3] No other jurisdiction has determined that there is a state interest in the "sanctity of life" which could outweigh the individual's right to forgo treatment under these circumstances. The Massachusetts Supreme Court, for example, saw the protective role of government quite differently:

> The duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity [citation omitted]. It is antithetical to our scheme of ordered liberty and to our respect for the autonomy of the individual for the State to make decisions regarding the individual's quality of life.

Brophy v. New England Sinai Hospital, 398 Mass. 417, 434, 497 N.E.2d 626, 635 (1986). When states express such widely divergent interests, the results are chaotic for patient care which is based on national medical standards.

Presently, where you live has a profound effect on whether you will be allowed to die, under what circumstances treatment can be stopped and how clear the evidence of your wishes must be. Across the country, an

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[3] Only one court arrived at a similar result, but on the narrow ground that the legislature should resolve the issue of artificial nutrition and hydration. *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988).

overwhelming majority of citizens believe strongly that the right to make medical decisions includes a right to forgo life sustaining treatment and that those choices should remain within the family. A 1986 American Medical Association poll indicated that 73% of 1,510 respondents favored "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it," American Medical Association, "Public Opinion on Health Care Issues-1986," Chicago, Ill. (1986). A teleconference poll moderated by Ted Koppel revealed that 79% of those polled believe that quality of life determinations should be considered in the decision of whether to use life-sustaining technology, and 70% believe that the immediate family, not the courts, should decide in the case of an incompetent patient. New York Times, Dec. 2, 1986. A very recent survey conducted by the "Colorado Speaks Out on Health" project in Colorado University's Graduate School of Public Affairs revealed that 85% of those surveyed would not want to have their life maintained with artificial feedings if they became permanently unconscious and could not eat normally. Fort Collins Coloradoan, Sept. 29, 1988, p. 1.

The Missouri Supreme Court's decision will have national significance because it contradicts a uniform body of medical and legal authority which would have permitted the Cruzans to exercise their daughter's right to refuse artificial feeding, and would have protected the health care providers who honored such a request. See e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So.

2d 1331 (Fla. 1986); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *Gray v. Romeo*, 697 F. Supp. 580 (D. R.I. 1988). This decision, by a narrow majority, has an impact way beyond Missouri's borders, since the jurisprudence in the right to die area relies heavily on the reasoning of other state courts, with states barely glancing at their own law regarding informed consent or other relevant areas. See e.g., *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), *review denied* (Cal. July 28, 1988), *cert. denied*, 109 S. Ct. 399 (1988); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). The *Cruzan* decision has already been cited in two recent termination of treatment decisions from Florida and Connecticut. *In re Guardianship of Browning*, No. 88-02887 (Fla. Dist. Ct. App. April 10, 1989); *McConnell v. Beverly Enterprises*, 209 Conn. 692, 553 A.2d 596 (1989).

Whether or not any other state will follow the *Cruzan* case's precedent, its holding resonates as a challenge to national uniformity in medical standards. National guidance from groups such as the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the American Medical Association, the American Academy of Neurology, the Office of Technology Assessment and the Hastings Center is thrown into question by the Missouri Supreme Court's ruling. If allowing a patient in a persistent vegetative state to die by withdrawing tube feeding is considered respecting a constitutional right and good ethical practice in Rhode Island, but is killing in Missouri, then the medical community has good reason to be confused about what to do in the absence of directly on-point case law.

Such confusion harms patients and their families on a daily basis:

> When decisions are made based on fear of liability, the focus of the decision shifts from a medical and ethical inquiry about the patient's interest to a strictly legal assessment of the provider's concerns.

NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT, 9 (1987). *See also*, U.S. CONGRESS: OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY, 20, 49 (1987).

Our experience is that the provider's concerns about legal liability will most likely be met by continuing the treatment, regardless of the family's wishes, the patient's prognosis or the treatment's benefit to the patient. This frequent practice is at the emotional and financial expense of the most vulnerable participants in the decision making process—the patient and family—who are also those least likely to know their right to contest the doctor or the institution's view of the law.

Not only was the *Cruzan* case wrongly decided, but its confused reasoning has significant day-to-day ramifications for patients. While a few highly publicized court cases may make these issues seem novel, the realities of medical practice are that this type of decisionmaking is common. In Minnesota, it was estimated that even five years ago, ten life support systems a week were disconnected. *In re Torres*, 357 N.W.2d 332, 341 (Minn. 1984). A 1988 American Medical Association poll showed that 67% of the 1,000 physicians surveyed had been personally involved in patient care where the issue of either refusal or withdrawal of treatment arose. Only 43% of the physicians surveyed stated that they were certain of the legal risks and responsibilities surrounding a decision to withdraw treatment; 54% admitted uncertainty. New

York Times, June 5, 1988, p. 23. As previously stated, the *Cruzan* decision has already increased that confusion. If the decision does not lead to routine continuation of treatment, regardless of family and patient wishes, it alternatively may drive medical practice further away from legal and public scrutiny. When ethical practice is in such direct conflict with the law, doctors, rather than practicing with full communication and documentation, may continue to do what they believe to be right, but in a secretive manner. See e.g., NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, DO NOT RESUSCITATE ORDERS, 7 (1986).

Families are now forced, as a result of the split among jurisdictions, to seriously consider a new and macabre form of forum shopping—transferring patients to states where they will be allowed to die. Nancy Cruzan's family clearly could have stopped treatment legally in at least Arkansas, California, Connecticut, Florida, Maine, Massachusetts, New Jersey, New Mexico or Rhode Island under either the applicable statutory or case law. Where the governing law does not clearly permit the withholding or withdrawal of treatment, or the health care providers simply refuse, many families nonetheless will seek to have their loved one's wishes honored rather than watch dignity deteriorate.

The Society frequently receives requests from families asking for assistance in the transfer of patients to states where the law would allow treatment to be ended. Such an option would appear to be legally permissible, since there are no apparent residency requirements for either the common law or natural death legislation to apply. Nonetheless, such requests are often futile, since as a practical matter, few institutions are willing to admit patients solely for the purpose of withdrawing treatment. Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 444 (1988). Such an admission is even more un-

likely for patients who have been transported over state lines. Even if transfer were possible, patients should not have to leave their home states because they have become hopelessly ill.

The *Cruzan* court also adversely affected family decisionmaking and violates national medical standards in that it drew a major distinction between withholding the feeding tube and withdrawing it. Pet. App. 34. The Court implied that treatment could be withheld but not withdrawn. This holding conflicts with every other state court to rule on the issue. See, e.g. *Gray v. Romeo*, 697 F. Supp. 580 (D. R.I. 1988); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 438, 497 N.E.2d 637-638 (1986); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Barber v. Superior Court for Los Angeles County*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). As other courts have noted, treatment should be instituted to see if it improves a patient's medical condition. To encourage withholding treatment, because withdrawing it later would be legally impermissible, will result in disastrous pressures on families, who will be forced to make life or death decisions before a reliable prognosis can be ascertained. The *Cruzan* ruling is one which other courts have specifically disapproved, since it "would discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die." *In re Conroy*, 90 N.J. 321, 370, 486 A.2d 1209, 1234 (1985).

Nancy Cruzan is condemned to another possible thirty years of non-conscious existence because a bare majority of the Missouri Supreme Court sanctimoniously refused to authorize her loved ones' decision to allow her to die because it was a judgment about the quality of her life. The Court itself made the decision about what was acceptable for Nancy, and ignored the people who knew her and can speak for her now, her family. In so doing,

they have taken control over medical technology away from countless other families across the country, and thrown medical decisionmaking into chaos. Physicians who were previously guided by family wishes and the ethical statements of their professional organizations are now mandated to practice inappropriate medicine. Patients will be the ones to suffer.

CONCLUSION

For the foregoing reasons, *amicus* urges this Court to grant the petition for certiorari.

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